STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING _____ B. WING _____	R-C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	**1345 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00141184 completed on 12/23/13.

This visit was in conjunction with a Post Survey Revisit (PSR) to a recertification and State Licensure Survey completed on 12/23/13.

Complaint # IN00141184: Corrected

Survey Dates: 1/30/14.

Facility number: 000005
Provider number: 155005
AIM number: 100270840

Survey Team:
Tina Smith-Staats, RN, TC
Karen Lewis RN
Ginger McNamee, RN
Toni Maley, BSW

Census bed type:
SNF: 34
SNF/NF: 119
Total: 153

Census payor type:
Medicare: 26
Medicaid: 97
Other: 30
Total: 153

Sample: 3

Manorcare Health Services was found to be in compliance with 42 CFR Part 483, Subpart Band

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING _____ B. WING _____	R-C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	**1345 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00141184.	{F 000}		